Supreme Court, U.S.
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No. 00-1021

IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC., *Petitioner*,

RECEIVE

v.

DEBRA C. MORAN AND STATE OF ILLINOIS, *Respondents.*

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

REPLY BRIEF FOR PETITIONER

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The briefing highlights the fact that this case brings the Court to a crossroads in its ERISA preemption jurisprudence. The path we urge the Court to take begins with a recognition that this Court meant what it said in *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41, 52, 57 (1987), when it ruled that Congress intended "ERISA's civil enforcement scheme [to] be exclusive" and to preempt state-law "remedies for the improper processing of a claim for benefits under an ERISA-regulated plan." It requires only the conclusion that a state law allowing beneficiaries dissatisfied with their ERISA plan's benefits determination to secure a ruling from a different decisionmaker overturning that determination is in fact a "remed[y] for the improper processing of a claim for benefits." That path offers the advantages of consistency and a clear and simple rule that the circuit courts can appreciate and follow. If Congress disagrees with it, Congress can change it—something Congress has not chosen to do in the fourteen years since *Pilot Life*.

Respondents and their amici would have the Court go down a different route, although there are as many different and contradictory maps of that route as there are bottom-side briefs. The Federal Government's position *du jour*, for example, is that this Court in *Pilot Life* meant only that state *court* remedies were preempted (though the Solicitor General does not explain why anyone would have thought such a system made sense), and that alternative state-law remedies for ERISA benefits, such as Section 4-10, are acceptable so long as they are enforced in an ERISA action—under what, if any, standard of review being left deliberately vague. *See* U.S. Br. 26-27 & n.13. Other independent review schemes would be preempted if the reviewer's decision were enforced in state court, if the reviewer could assess punitive damages, or if beneficiaries (as opposed to the plan) could be forced to undergo the review.

However self-assured the Federal Government might be about the ultimate wisdom of this latest refinement of its position, no one can seriously suggest that its various caveats, provisos, assumptions, and unresolved issues furnish a useful or usable guide for the circuit courts confronted with the next ERISA preemption issue—or even a meaningful test for deciding whether any of the other 39 state independent review laws, each with its particular features, passes muster. Adopting such an approach simply guarantees that the circuit courts will continue to reach conflicting results at an alarming rate. The Court should not muddy further its ERISA preemption jurisprudence with such a preciously refined analysis. It should instead dare to paint with primary colors in this case, hold that it meant what it said in *Pilot Life*, and that the remedy provided by Section 4-10 is therefore preempted.

I. SECTION 4-10 CONFLICTS WITH ERISA'S EXCLUSIVE REMEDIAL SCHEME

ERISA provides a remedy for beneficiaries dissatisfied with a plan's determination of benefits: an action under

Section 502(a), 29 U.S.C. § 1132(a), in which the court examines whether the plan fiduciary abused the discretion granted it under the plan. *See Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 111 (1989). The remedy chosen by Moran, in contrast, consists of state-compelled, binding independent review under Section 4-10, in which an independent physician determines, apparently de novo, whether a benefit is covered. Section 4-10 directs that Rush "shall provide" the service if the reviewer determines that it is covered. That remedy squarely conflicts with Congress' intent, recognized in *Pilot Life*, that ERISA's remedies are *exclusive* and that state laws that supplement or supplant those remedies are preempted.

Respondents and their amici maintain that the alternative remedy chosen by Moran does not conflict with ERISA's exclusive remedies, for three principal reasons. First, they argue that because parties could voluntarily agree to internal review procedures resembling Section 4-10, States can compel such procedures. Second, they argue that Section 4-10 is not really an alternative remedy at all because it is not, at least in the first instance, a judicial remedy. Third, they argue that the Section 4-10 remedy is not preempted because it provides only the relief available under ERISA, and no more. None of these arguments withstands scrutiny.

A. Section 4-10 Is Preempted Regardless Of Whether A Plan Could Voluntarily Agree To Arbitration As Part Of The Plan's Internal Review

Respondents and their amici contend that ERISA permits plans to adopt arbitration procedures as part of their internal benefit determination processes. Therefore, they argue, Section 4-10 must not conflict with ERISA either. *See, e.g.*, Moran Br. 35; U.S. Br. 29; Illinois Br. 29-31; NAIC Br. 17-18; AMA Br. 22-23.

But whether parties to an ERISA plan may voluntarily agree to arbitration as part of the plan's internal procedures

says nothing about whether state laws can *compel* additional or alternative *external* remedies for beneficiaries seeking to challenge benefits determinations. Respondents and their amici cite no preemption precedent suggesting that this consideration is at all pertinent to the analysis, and it plainly is not. For example, nothing prevented employers in *Gade* v. *National Solid Waste Management Ass'n*, 505 U.S. 88 (1992), from voluntarily requiring that their employees log 500 days of training, but that did not save a state law imposing the same requirement from preemption. Nothing prevented manufacturers in *Geier* v. *American Honda Motor Co.*, 529 U.S. 861 (2000), from voluntarily installing airbags in their automobiles in 1984, but that did not save state law imposing the same safety standard from preemption. Likewise, ERISA is regularly found to preempt state laws imposing requirements that plans are perfectly free to adopt voluntarily.[1]

ERISA's principal purpose is to allow administrators of nationwide plans "to establish a uniform administrative scheme" with "a set of standard procedures to guide processing of claims and disbursement of benefits," free from the specter of fifty different state laws. *Egelhoff*, 121 S. Ct. at 1328 (quotation omitted). That purpose is served by permitting parties to a plan to adopt voluntary and uniform benefit determination procedures. It is not served if each and every State can impose its own remedy for beneficiaries dissatisfied with the plan's determinations.

For the same reason, Moran's contention that Section 4-10 does not conflict with ERISA's internal review requirements,

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[1] *See, e.g.*, *Egelhoff* v. *Egelhoff*, 121 S. Ct. 1322 (2001) (state statute mandating particular beneficiary designation preempted); *District of Columbia* v. *Greater Washington Bd. of Trade*, 506 U.S. 125 (1992) (state law requiring employers to provide particular level of health insurance for injured employees eligible for workers' compensation preempted).

Br. 35-40, is beside the point. Section 4-10 is not a different way for the plan to reach its own internal decision; it is an external means through which a beneficiary can challenge that decision. That conflicts with Congress' intent that an action under Section 502(a) be the exclusive means of reviewing plan determinations. *Pilot Life*, 481 U.S. at 52, 57.

The Solicitor General and other amici rely on an analogy to Section 301 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 185, which, as the Court has noted, was a model for ERISA's preemptive scope. *See* U.S. Br. 23, 28; AMA Br. 22; NAIC Br. 17. The analogy hurts their cause. The Solicitor General observes that the LMRA encourages private arbitration agreements as the means of resolving disputes under collective bargaining agreements ("CBAs"). From this, he concludes that Section 4-10 must be permissible under ERISA because it simply establishes a type of arbitration. *See* U.S. Br. 28. His premise is wrong. The LMRA has no preference for arbitration *per se*; it embodies a preference for resolving disputes under CBAs *in the manner agreed to by the parties*.[2] Purely voluntary

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[2] *See, e.g.*, *United Steelworkers of Am.* v. *American Mfg. Co.*, 363 U.S. 564, 566 (1960) (policy of LMRA "can be effectuated only if the means chosen by the parties for settlement of their differences under a collective bargaining agreement is given full play"); *United Steelworkers of Am.* v. *Warrior & Gulf Nav. Co.*, 363 U.S. 574, 581 (1960) ("[An arbitrator] is not a public tribunal imposed upon the parties by superior authority which the parties are obliged to accept. * * * He is rather part of a system of self-government created by and confined to the parties.") (quotation omitted); *Graphic Communications Int'l Union, Local 735-S* v. *North Am. Directory Corp. II*, 98 F.3d 97, 101 n.5 (3d Cir. 1996) ("It is not arbitration per se that federal policy favors, but rather final adjustment of differences by a means selected by the parties.") (quotation omitted); 29 U.S.C. § 173(d) ("Final adjustment by a method *agreed upon by the parties* is declared to be the desirable method for settlement of grievance disputes arising over

agreements to arbitrate are consistent with that policy. But a state law imposing a particular arbitral remedy *not* agreed to by the parties conflicts with the central policies of the LMRA. It is not surprising, then, that the LMRA preempts state proceedings involving interpretation of CBAs, even where the state remedies are non-judicial. *See, e.g., Carver Lumber Co.* v. *Illinois Human Rights Comm'n*, 515 N.E.2d 417 (Ill. App. Ct. 1987) (LMRA preempted state administrative proceeding). The LMRA would likewise preempt a state law compelling independent review of a provision of a CBA in a manner contrary to the CBA. The same is true under ERISA.

Moreover, Section 4-10, while similar to arbitration, is quite different from the form typically found in voluntary agreements. Section 4-10 is binding on HMOs once it is invoked, but unlike arbitration agreements, beneficiaries are not obligated to invoke the Section 4-10 remedy. They may elect to pursue ERISA remedies instead. And, under respondents' theory, they would even be entitled to two bites at the apple: if a claim is denied by the Section 4-10 reviewer, a beneficiary could file an ERISA action seeking the same benefits. That is nothing like a voluntary arbitration procedure, but is instead an alternative remedy mandated by state law.

Recognizing this one-sided process, the Solicitor General notes that under Department of Labor regulations " 'claimants cannot be required to submit their claims to [state law external review] procedures in order to be entitled to file suit under the Act.' " U.S. Br. 22 (quoting 65 Fed. Reg. 70,254) (Nov. 21, 2000). *See also* 29 C.F.R. § 2560.503-1(k)(2)(i)-(ii). Thus, the Federal Government understands that ERISA would preempt state laws requiring *beneficiaries* to undergo external review, presumably because such laws—even

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the application or interpretation of an existing collective-bargaining agreement.") (emphasis added).

though resembling arbitration—would conflict with ERISA's exclusive remedies. The same must be true of Section 4-10, which mandates that plan administrators undergo the same kind of procedure.[3] The state law seeks to supplant or supplement ERISA's exclusive remedies in both cases, and is therefore preempted.

Deeming Section 4-10 to be part of the plan's internal decisionmaking also conflicts with ERISA's fiduciary requirements. *See* Pet. Br. 22-23 n.5. An independent reviewer is neither a plan fiduciary under Section 503 of ERISA, *see* 29 U.S.C. § 1133(2), nor someone the plan fiduciary has delegated to carry out plan functions. *See id.* § 1105(c)(1)(B); Illinois Br. 34. As the Solicitor General notes, under ERISA "the decisionmaker's fiduciary duty is to be faithful to the terms of the plan." U.S. Br. 9 n.4. This ensures that administrators give proper consideration to plan terms, and prevents them from giving unwarranted benefits to some beneficiaries in a way that jeopardizes coverage for others. Under ERISA, the fiduciary's decision is reviewed to determine whether the fiduciary abused the discretion the plan entrusted to it. Under Section 4-10, by contrast, a binding decision is made by an independent reviewer without any fiduciary obligation to the plan. *See* AMA Br. 3.

The Solicitor General responds that independent review laws do not conflict with ERISA's fiduciary requirements because "Section 503 * * * governs internal plan appeals, not external review." U.S. Br. 24-25 n.12. He cannot have it both ways. If Section 4-10 is an external remedy and therefore ungoverned by Section 503's fiduciary requirements, it is preempted under *Pilot Life*. If it is an internal remedy—

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[3] It is no answer to say that Section 502 confers rights of action only on beneficiaries, not plans. *See* U.S. Br. 23. Section 502(a)(3)(B) authorizes suits by plan fiduciaries to "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(3)(B)(ii).

which it plainly is not—such a state-imposed remedy conflicts with the fiduciary requirements of Section 503.

B. ERISA Preempts All Alternative Or Additional State Law Remedies, Not Just Judicial Remedies

Respondents and their amici argue that Section 4-10 is not preempted under *Pilot Life* and its progeny, because the remedy provided by Section 4-10 is not (at least in the first instance) a judicial one. There is no conflict with ERISA's exclusive remedies, they say, because the results of the Section 4-10 proceeding can be enforced in an ERISA action, in which the only role for the court is to require the payment of benefits as the independent reviewer has decreed. Under their theory, then, a State can mandate *any* alternative remedy for reviewing a plan's benefit determinations, so long as final enforcement of the decision is through a rubber-stamp ERISA action. In their view and that of the Seventh Circuit, the Section 4-10 remedy is simply a term of the plan, and there is no conflict with ERISA's exclusive remedies because relief awarded by the Section 4-10 reviewer must still be enforced through an ERISA action. They are mistaken. Section 4-10 is as much an alternative remedy as any judicial action, and it should be treated no differently under ERISA.

The only pertinent difference between Section 4-10 and a judicial remedy is that the decisionmaker under Section 4-10 is a physician, while the decisionmaker in a judicial action is a judge or jury. But arbitration is still a remedy, even if an arbitrator's decision must be enforced through a subsequent judicial action. *See* Pet. Br. 31-32 n.10. Respondents do not refute that point. Nor could they, given this Court's repeated references to the "remedy" of arbitration.[4]

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[4] *See, e.g.*, *Air Line Pilots Ass'n* v. *Miller*, 523 U.S. 866, 876, 880 (1998) (referring to "arbitral remedy" and "arbitration remedy"); *DelCostello* v. *International Bhd. of Teamsters*, 462 U.S. 151, 163 (1983) (referring to "arbitration remedies"); *Great Am. Fed. Sav. & Loan Ass'n* v. *Novotny*, 442 U.S. 366, 377-378 (1979) (arbitration and litigation are "alternative remedies").

Respondents' argument also proves too much. It would allow States to circumvent ERISA preemption simply by deeming alternative remedies to be "plan terms" enforceable through an ERISA action. For example, a State could require plans to include procedures under which claims for benefits would be determined by a panel of twelve citizens selected from the voter rolls (*i.e.*, a jury), or by a person holding the qualifications of a state court judge, or by an administrative tribunal. Under the theory that ERISA's exclusive remedies preempt only coercive judicial enforcement mechanisms, *see, e.g.*, U.S. Br. 23; NAIC Br. 13, a State could even require plans to abide by state court declaratory judgments awarding benefits, provided the actual enforcement of those decisions is through an ERISA action. In respondents' view, none of these state laws would conflict with ERISA's exclusive remedies, because the outcome of each proceeding would be enforced through a rubber-stamp ERISA action.

Permitting such legerdemain would nullify ERISA's exclusive remedies. The uniformity of those remedies—"one of the essential tools for accomplishing the stated purposes of ERISA," *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 137 (1990) (quotation omitted)—would be destroyed if a State could mandate additional or alternative remedies simply by calling them plan terms. Respondents hardly address this argument. For example, they do not attempt to explain why, under their theory, ERISA would preempt state laws mandating juries or other external decisionmakers as incorporated plan terms, but not state laws mandating physician decisionmakers. Nor do they explain why, under their theory, ERISA would preempt a statute allowing an independent reviewer to award punitive damages or other relief not available in an ERISA action.[5] ERISA preempts all such

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[5] The Solicitor General responds only that States could not impose terms requiring plans to abide by punitive damages

laws for the same reason it preempts Section 4-10: such additional or alternative remedies interfere with ERISA's exclusive remedies.

Moreover, the rubber-stamp role to which respondents would relegate the federal courts in this case would raise profound concerns under Article III, because there is no federal law to apply or develop in the purportedly federal action to enforce the independent reviewer's decision. *See* Pet. Br. 25-26 n.6. The Solicitor General's rebuttal is unresponsive: he simply analogizes to the development of federal common law concerning arbitral decisions under the LMRA. U.S. Br. 23-24 n.11. His citation to *Textile Workers Union* v. *Lincoln Mills*, 353 U.S. 448 (1957), shows how far afield his analogy is. The referenced page of *Lincoln Mills* notes that federal courts may adopt compatible state law, but that "[a]ny state law applied * * * will be absorbed as federal law and will not be an independent source of private right[s]." *Id.* at 457. Here, state law provides the binding remedy being implemented in the federal court action under Section 502(a); the Seventh Circuit did not suggest that it was "absorbing" the Illinois independent review regime as federal law.

Illinois' reliance on *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358 (1999), *see* Illinois Br. 27-28, 28 n.9, is likewise misplaced. This is not a case, as in *UNUM*, where state law supplies one of the relevant rules of decision in an action otherwise governed by federal law. *See* Pet. Br. 30-31.

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determinations "because private parties could not meaningfully contract for such a cause of action." U.S. Br. 20. That is not true: under Illinois law, arbitrators may award punitive damages if the parties have so agreed. *7-Eleven, Inc.* v. *Dar*, 757 N.E.2d 515, 523 (Ill. App. Ct. 2001); *Edward Elec. Co.* v. *Automation, Inc.*, 593 N.E.2d 833, 843 (Ill. App. Ct. 1992), *appeal denied*, 602 N.E.2d 450 (Ill. 1992). And even if its common law were otherwise, a State could override such restrictions by statute.

There is *no* function for federal courts at all under Section 4-10, other than to rubber-stamp a decision reached by a state-mandated decisionmaker applying a state statute. That is in fact what the court below did in this case. *See* Pet. App. 24a.[6]

C. ERISA Preempts Alternative State Law Remedies, Not Just Those Seeking Additional Relief

Illinois argues that Section 4-10 does not conflict with ERISA's exclusive remedies because Moran seeks only recovery of benefits—relief that would otherwise be available under ERISA. *See* Illinois Br. 26; *see also* U.S. Br. 21; State Amici Br. 23-24; AMA Br. 21. That argument is foreclosed by *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. 58 (1987), which held that ERISA preempts even those state law claims, like breach of contract claims, that seek relief also available under ERISA. The Court held in *Taylor* that a claim seeking "compensatory damages for money contractually owed Plaintiff" under a disability benefits plan was not only preempted, but so completely preempted as to permit removal to federal court. *Id.* at 61, 62-67. As the Court noted the same day in *Pilot Life*, ERISA preempts state laws that either "supplement[ ] *or* supplant[ ]" ERISA's exclusive remedies. 481 U.S. at 56 (emphasis added). Thus, the lower courts have uniformly held that ERISA preempts state law

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[6] Moran argues that a federal court "will have the same function it always had under [Section 502(a)]." Br. 39-40 n.18. But there is a world of difference between a federal court construing a document under developing standards of federal common law (including standards of review) and a federal court merely enforcing a state law providing that an HMO "*shall* provide the covered service" if an independent reviewer decides that the service is medically necessary. 215 Ill. Comp. Stat. 125/4-10 (emphasis added).

contract actions even if those actions seek the same recovery available under ERISA.[7]

The reason is clear: even if an alternative remedy provides the same relief as an ERISA action, allowing each State to impose its own such remedy, with differing standards and decisionmakers, is "fundamentally at odds with the goal of uniformity that Congress sought to implement." *Ingersoll-Rand*, 498 U.S. at 142.[8]

II. SECTION 4-10 IS NOT SAVED BY ERISA'S SAVING CLAUSE

A. Under *Pilot Life*, Laws That Conflict With ERISA's Exclusive Remedies Do Not Fall Within ERISA's Saving Clause

The central holding of *Pilot Life* is that state laws seeking to supplement or supplant ERISA remedies are necessarily preempted, regardless of whether such laws would otherwise fall within ERISA's saving clause. Thus, because Section 4-10 conflicts with ERISA's exclusive remedies, there is no need for the Court even to consider the other tests to determine if it is within the saving clause. *See* Pet. Br. 32-36.

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[7] *See, e.g.*, *Bowles* v. *Quantum Chem. Co.*, 266 F.3d 622, 631 (7th Cir. 2001); *Aetna Life Ins. Co.* v. *Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000); *Kolasinski* v. *Cigna Healthplan of CT, Inc.*, 163 F.3d 148, 149 (2d Cir. 1998); *Board of Trustees of Hotel & Rest. Employees Local 25* v. *Madison Hotel, Inc.*, 97 F.3d 1479, 1486-87 (D.C. Cir. 1996).

[8] In addition, it is not correct to regard the remedy provided by Section 4-10 as merely duplicative of ERISA remedies. *See* Pet. App. 25a-26a (Section 4-10 "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans. * * * The suit for breach of contract envisaged by the statute becomes a suit for judicial review of the independent physician's decision.") (Posner, J., dissenting from denial of rehearing en banc).

Illinois, however, contends that this central holding was dicta. *See* Illinois Br. 35-36; *see also* NAIC Br. 20. That argument is untenable. *Pilot Life* held that the state law remedies at issue there were not within the scope of the saving clause, and were therefore preempted. *Pilot Life*, 481 U.S. at 57 (concluding that state law claim was "not saved by § 514(b)(2)(A), and is therefore preempted by § 514(a)"). According to the Court, the "most important[ ]" factor leading to that result was "the clear expression of Congressional intent that ERISA's civil enforcement scheme be exclusive." *Id.* Thus, the Court's recognition that ERISA's remedies are exclusive was the "most important" part of its holding that additional or alternative remedies are not within the scope of the saving clause, and are therefore preempted. That is not dicta.

This fact also disposes of the argument that *Pilot Life* is somehow inconsistent with the language of the saving clause. *See, e.g.*, NAIC Br. 22-24; United Policyholders Br. 10. The Court did not hold that laws that fall within the terms of the saving clause are nevertheless preempted when they seek to supplement or supplant ERISA's exclusive remedies. Rather, the Court held that a law that seeks to supplement or supplant ERISA's exclusive remedies does not fall within the terms of the saving clause at all, because such a law does not "regulate[ ] insurance." 29 U.S.C. § 1144(b)(2)(A). Rather than regulate insurance—a subject ERISA does not address—such a law regulates the procedural remedies for enforcing rights under ERISA plans, a subject reserved exclusively to ERISA and the federal common law developed under it. *Cf.* U.S. Br. 4 (recognizing that claims processing is a "core concern" of ERISA). In fact, as shown below, *infra* at 14-18, Section 4-10 does not even regulate insurance within the meaning of the other saving clause factors.

That *Pilot Life* controls this case is demonstrated by the fact that several of respondents' amici urge the Court to overrule that decision. *See* United Policyholders Br. 28;

AARP Br. 23-28; California Consumer Br. 6. We have shown why there is no cause for the Court to do so. *See* Pet. Br. 34-35. ERISA preemption law is already confused enough, as evidenced by the twenty cases already decided by the Court and the four more (at least) awaiting action on the Court's docket,[9] not to mention the twists and turns of the various positions of the United States.[10] Extinguishing one of the few beacons of clarity in this area would exponentially exacerbate the confusion in the law.

B. The Other Saving Clause Factors Demonstrate That Section 4-10 Does Not Regulate Insurance

1. Even if the Court were to consider the other saving clause factors, those factors likewise demonstrate that Section 4-10 does not fall within the insurance saving clause. The first of these factors should also be the most straightforward: common sense. *See UNUM*, 526 U.S. at 367. In order for the common-sense inquiry to have any significance independent of the three McCarran-Ferguson guideposts, however, it must operate as something more than a free-wheeling judgment about whether the challenged law "regulates insurance." It should function as an inquiry into whether the state law at issue has historically been regarded as a type of insurance regulation reserved to the States.

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[9] *See United States Healthcare Sys. of Pa., Inc.* v. *Pennsylvania Hosp. Ins. Co.*, No. 01-200; *Kentucky Ass'n of Health Plans, Inc.* v. *Miller*, No. 00-1471; *Community Health Partners, Inc.* v. *Kentucky*, No. 00-1295; *Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665.

[10] *Compare* U.S. Br. 28-29 n.14 *with* U.S. Br. 22-23 & n.12, 24 n.13, 25 & n.14, *UNUM Life Ins. Co.* v. *Ward*, No. 97-1868 (filed Dec. 2, 1998) *and* U.S. Br. 18-19, *Pilot Life Ins. Co.* v. *Dedeaux*, No. 85-1043 (filed May 30, 1986); *see also* Pet. Supp. Br. 1-2, *United States Healthcare Sys. of Pa., Inc.* v. *Pennsylvania Hosp. Ins. Co.*, No. 01-200 (filed Nov. 19, 2001) (noting three different positions taken by United States in that case).

Thus, for example, in *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 742-743 (1985), the Court upheld the mandated-benefit law at issue in large part on the ground that it had historically been regarded as a traditional insurance law.

Section 4-10, in contrast, is directed specifically at HMOs, which have historically been regarded by States as distinct from indemnity insurance providers.[11] Illinois itself provides that only a select set of Insurance Code provisions are applicable to state-certified HMOs, which are organized not under the Insurance Code, but under the Business Corporation Act. *See* 215 Ill. Stat. 125/5-3(a). And some HMOs, as we observed in our opening brief, may neither offer insurance products nor bear the risk for the health plans with which they contract. A law that is not specifically directed at risk-bearing entities, and that does not accomplish any risk spreading or transfer, does not regulate a business traditionally defined at its core essence as the shifting of risk.

2. Indeed, the first McCarran-Ferguson factor, the spreading or transfer of risk, is an "indispensable characteristic" of the business of insurance. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 212 (1979). An insurance regulation spreads risk by allocating it among a large pool of insureds; the mandated-benefits law at issue in *Metropolitan Life* v. *Massachusetts*, for example, spread risk by distribut-

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[11] *See, e.g.*, Cal. Ins. Code § 740(g) ("A health care service plan [*i.e.*, HMO] * * * shall not be subject to this section."); Fla. Stat. § 641.30(2) ("Except as provided in this part, the Florida Insurance Code does not apply to [HMOs] certificated under this part"); Va. Code § 38.2-4319(a) (stating that only enumerated provisions of the state insurance code apply to HMOs); N.J. Stat. 26:2J-25a ("Except as otherwise provided in this act, provisions of the insurance law * * * shall not be applicable to any [HMO] granted a certificate of authority under this act."); Md. Health-Gen. Code § 19-706(c) ("Except as otherwise provided in this subtitle, [an HMO] is not subject to the insurance laws of this State.").

ing treatment costs for a small but high-risk pool of insureds among a far larger number of policyholders. 471 U.S. at 731, 743. And as this Court explained in *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 130-131 (1982), risk transfer—the shifting of risk from one party to another—occurs when the parties enter into an insurance contract, because the policy defines "the measure of the risk that has actually been transferred to the insurer." *Id.* at 130.

The Seventh and Fifth Circuits largely conceded that independent review provisions like Section 4-10 do not spread or transfer risk. *See* Pet. Br. 40 n.16. Independent review laws do not spread risk because they do not mandate that a class or type of benefits be disbursed to all policyholders. Nor do such laws affect risk allocation between parties at the time they enter into an insurance agreement; such laws are "logically and temporally unconnected to the transfer of risk." *Pireno*, 458 U.S. at 130. Moran argues that Section 4-10 may, in certain instances, shift costs to an HMO if its medical necessity decision is overridden. Moran Br. 26. But so do ERISA's remedies, Pet Br. 41 n.17, and so do all state laws that place financial burdens on HMOs. That does not suffice to transform the state law into one that "spreads risk."

3. Section 4-10 is not an "integral part of the policy relationship"—the next McCarran-Ferguson factor—because the law does not "define the terms of the relationship" between insurer and insured. *Metropolitan Life* v. *Massachusetts*, 471 U.S. at 743; *Pilot Life*, 481 U.S. at 51. Section 4-10 does not "change the bargain between insurer and insured," like the law at issue in *UNUM*, 526 U.S. at 374. The terms of the bargain remain the same. The law simply supplies an alternative mechanism by which plan beneficiaries can enforce the plan's terms. That is why, under *Pilot Life*, it is preempted.

4. Nor does Section 4-10 satisfy the final McCarran-Ferguson factor—whether the law is "limited to entities

within the insurance industry." *UNUM*, 526 U.S. at 375. Section 4-10 applies to HMOs regardless of whether they act as insurers or as administrators for other risk-bearing groups. *See Insurance Bd. of Bethlehem Steel Corp.* v. *Muir*, 819 F.2d 408, 412 (3d Cir. 1987) (law impacting Blue Cross & Blue Shield acting as a plan administrator did not satisfy third McCarran-Ferguson factor, because administrator was an "entit[y] outside the industry").

The Solicitor General contends that even HMOs performing administrative functions still bear risk in some distant sense, because those functions may be "associated with the risk-bearing function." Br. 15. But performing tasks "associated with" risk-bearing is not nearly the same as actually bearing risk. *See Powell* v. *Chesapeake & Potomac Tel. Co. of Va.*, 780 F.2d 419, 423 (4th Cir. 1985) (insurance company acting as plan administrator "neither spreads nor underwrites insurance risks; * * * [it] provides certain purely administrative claims processing functions"), *cert. denied*, 476 U.S. 1170 (1986).

The Solicitor General, joined by Illinois, also suggests more boldly that HMOs which do not bear risk necessarily "retain an insurance function" because the claims processing services they perform are "inextricably intertwined with insurance and the bearing of risk." U.S. Br. 15; *see* Illinois Br. 18. Surely not. A business performing outsourced claims processing services for a traditional insurer does not become an "insurer" just because it pushes paper for the insurance company. *See Insurance Bd. of Bethlehem Steel Corp.*, 819 F.2d at 413 (company that processed claims and paid benefits for corporate benefit plan was not engaged in the "business of insurance"); *Powell*, 780 F.2d at 423.

Respondents are left with the unsatisfying argument that Section 4-10 actually applies to HMOs "only when they are acting as insurers." Illinois Br. 21; *see* Moran Br. 22; Pet. App. 17a. That is not what the law says. It applies to *all*

HMOs, including those that shift risk to their providers and those that manage health plans for other entities. Those HMOs may be health care administrators, or there may be some other name for the function they serve; but they are not insurers. Because Section 4-10 applies with equal force to entities outside the insurance industry, it does not satisfy the third McCarran-Ferguson factor.

III. SECTION 4-10 CONCEDEDLY RELATES TO ERISA PLANS

The above discussion demonstrates that Section 4-10—which provides an alternative remedy to recover benefits under an employer-sponsored health plan—falls within ERISA's broad preemption provision because it "relates to" ERISA plans. As the Seventh Circuit held, Section 4-10 relates to ERISA plans "because its provisions have a connection with such plans." Pet. App. 15a-16a; *see Ingersoll-Rand*, 498 U.S. at 139. Illinois concedes the point, Br. 13, as does the Solicitor General. U.S. Br. 6-7.

Respondent Moran's lead-off argument, however, is that Section 4-10 does not "relate to" ERISA plans. *See* Br. 16-21. She waived this argument by failing to raise it below. *TRW, Inc.* v. *Andrews*, 122 S. Ct. 441, 450-451 (2001). Indeed, in the Court of Appeals, Moran conceded that Section 4-10 related to ERISA plans. *See* Pet. App. 15a ("agree[ing] with the parties" that Section 4-10 related to ERISA plans); *id.* 25a ("The state law is conceded to relate to ERISA plans").[12]

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[12] Amici AARP, Br. 7-16, and the States, Br. 6-17, similarly argue that the law does not "relate to" ERISA plans, but amici cannot raise arguments the parties have not or cannot raise themselves. *See Reno* v. *Koray*, 515 U.S. 50, 55 n.2 (1995). The same rule precludes the radical argument of amicus United Policyholders that ERISA was not meant to apply to health benefit plans in the first place. Br. 14-21. In any case, ERISA governs "*any* plan, fund, or program" maintained "for the purpose of providing for its

In any event, Moran's new argument is meritless. Moran argues that Section 4-10 "neither refers to nor has a significant connection with ERISA plans" because it applies only to HMOs. Br. 20.[13] But as the Court of Appeals held, the Illinois law requires HMOs, "including those that are service providers for ERISA plans, to provide an independent review mechanism" for medical necessity determinations. Pet. App. 16a. The law plainly "has an effect on how benefit determinations are made, and, thus, squarely falls within ERISA's preemption clause." *Id.*

The amici States argue, for their part, that Section 4-10 does not "relate to" ERISA plans because it regulates only "medical treatment" decisions, and *Pegram* suggests that such laws are not pre-empted. Br. 13; *see id.* 17. *Pegram* has nothing to do with preemption, and we agree with the Solicitor General that it does not control the question here. U.S. Br. 7-11. Nor is the States' initial assumption—that independent review laws regulate "medical treatment" decisions—correct. The determinations at issue here are not treatment decisions, but coverage decisions, in which HMOs, pursuant to the terms of their plans, determine whether a service is a covered benefit. That determination requires plan

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participants or their beneficiaries, through the purchase of insurance or otherwise, (A) *medical, surgical, or hospital care or benefits* * * *." 29 U.S.C. § 1002(1) (emphases added).

[13] Moran suggests that Rush improperly refers to the Rush Certificate of Coverage as the "ERISA plan," and that Rush provided "no evidence that it, its HMO insurance contract or services, or its member Certificate, is an ERISA benefit plan." Moran Br. 16-17. Moran's second amended complaint, however, itself states that "Rush Prudential's Certificate of Coverage * * * is an ERISA governed employer sponsored welfare benefit plan." J.A. 32, 38. *See also Pegram* v. *Herdrich*, 530 U.S. 211, 223 (2000) (the "agreement between an HMO and an employer who pays the premiums may * * * provide elements of a plan by setting out rules under which beneficiaries will be entitled to care").

fiduciaries to interpret the terms of the plan; "medical necessity" is not some brooding omnipresence in the sky. It is defined by the terms of the plan, and its application requires interpretation of the terms of the plan. That makes it a coverage determination.

Contrary to the concern expressed by the AMA, preempting state independent review laws would hardly lead to "no regulation" of HMOs and their medical-necessity determinations. Br. 23. States remain free to provide that HMOs must afford specified levels of coverage and to define benefits that must be covered. The remedy for an HMO's failure to fulfill its coverage obligations is then an action under Section 502. What States cannot do under ERISA, however, is supply alternative state-law remedies to enforce the terms of an ERISA plan. Section 4-10 seeks to do just that, and is therefore preempted.

CONCLUSION

For the foregoing reasons, and those in petitioner's opening brief, the judgment below should be reversed.

Respectfully submitted,

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